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BEFORE THE
BOARD OF REGISTERED NURSING
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against: **KELLY THERESA JOHNSON** 752 E. Ave. K 4 Lancaster, CA 93535 Registered Nurse License No. 581531 Respondent.	Case No. 2006-58 **ACCUSATION**

Complainant alleges:

PARTIES

1. Ruth Ann Terry, M.P.H., R.N. (Complainant) brings this Accusation solely in her official capacity as the Executive Officer of the Board of Registered Nursing, Department of Consumer Affairs (Board).

2. On or about June 1, 2001, the Board issued Registered Nurse License No. 581531 to Kelly Theresa Johnson (Respondent). The Registered Nurse License was in full force and effect at all times relevant to the charges brought herein and will expire on July 31, 2006, unless renewed.

JURISDICTION

3. This Accusation is brought before the Board, under the authority of the following laws. All section references are to the Business and Professions Code unless otherwise

indicated.

4. Section 2750 provides, in pertinent part, that the Board may discipline any licensee, including a licensee holding a temporary or an inactive license, for any reason provided in Article 3 (commencing with section 2750) of the Nursing Practice Act.

5. Section 2764, in pertinent part, that the expiration of a license shall not deprive the Board of jurisdiction to proceed with a disciplinary proceeding against the licensee or to render a decision imposing discipline on the license. Under section 2811(b), the Board may renew an expired license at any time within eight years after the expiration.

6. Section 2761 states, in pertinent part:

"The board may take disciplinary action against a certified or licensed nurse or deny an application for a certificate or license for any of the following:

"(a) Unprofessional conduct, which includes, but is not limited to, the following:

. . . .

"(d) Violating or attempting to violate, directly or indirectly, or assisting in or abetting the violating of, or conspiring to violate any provision or term of this chapter [the Nursing Practice Act] or regulations adopted pursuant to it. . . ."

7. Section 2762 states, in pertinent part:

"In addition to other acts constituting unprofessional conduct within the meaning of this chapter [the Nursing Practice Act], it is unprofessional conduct for a person licensed under this chapter to do any of the following:

"(a) Obtain or possess in violation of law, or prescribe, or except as directed by a licensed physician and surgeon, dentist, or podiatrist administer to himself or herself, or furnish or administer to another, any controlled substance as defined in Division 10 (commencing with Section 11000) of the Health and Safety Code or any dangerous drug or dangerous device as defined in Section 4022.

. . . .

"(e) Falsify, or make grossly incorrect, grossly inconsistent, or unintelligible entries in any hospital, patient, or other record pertaining to the substances described in

subdivision (a) of this section."

8. Section 4060 states, in pertinent part:

"No person shall possess any controlled substance, except that furnished to a person upon the prescription of a physician, dentist, podiatrist, optometrist, or veterinarian, or furnished pursuant to a drug order issued by a certified nurse-midwife pursuant to Section 2746.51, a nurse practitioner pursuant to Section 2836.1, a physician assistant pursuant to Section 3502.1, . . ."

9. Health and Safety Code section 11377, subdivision (a) provides that it is illegal to possess a controlled substance without a valid prescription.

10. California Code of Regulations, title 16, section 1444, states, in pertinent part:

"A[n] . . . act shall be considered to be substantially related to the qualifications, functions or duties of a registered nurse if to a substantial degree it evidences the present or potential unfitness of a registered nurse to practice in a manner consistent with the public health, safety, or welfare. Such convictions or acts shall include but not be limited to the following:

. . . .

"(c) Theft, dishonesty, fraud, or deceit. . . ."

11. Section 125.3 provides, in pertinent part, that the Board may request the administrative law judge to direct a licentiate found to have committed a violation or violations of the licensing act to pay a sum not to exceed the reasonable costs of the investigation and enforcement of the case.

CONTROLLED SUBSTANCES / DANGEROUS DRUGS

12. Darvocet, a combination drug containing propoxyphene napsylate and acetaminophen, is a Schedule IV controlled substance as designated by Health and Safety Code section 11057(c)(2) and categorized as a dangerous drug pursuant to Business and Professions Code section 4022. Darvocet N-100 is a trade name for the narcotic substance dextropropoxyphene or propoxyphene hydrochloride with the non-narcotic substance acetaminophen. It is a narcotic pain medication

13. Demerol, a brand of meperidine hydrochloride, a derivative of the narcotic substance pethidine, is a Schedule II controlled substance as designated by Health and Safety Code section 11055(c)(17) and is categorized as a dangerous drug pursuant to Business and Professions Code section 4022. It is a narcotic pain medication.

14. Dilaudid, an Opium derivative, is a Schedule II controlled substance as designated by Health and Safety Code section 11055(b)(1)(k) and is categorized as a dangerous drug pursuant to section 4022. Dilaudid is a trade name (Knoll) for the narcotic substance Hydromorphone. It is a narcotic pain medication.

15. Morphine Sulfate (MS), the narcotic substance is a preparation of Morphine, the principal alkaloid of opium. It is classified as a Schedule II controlled substance as designated by Health and Safety Code section 11055, subdivisions (b)(1)(M) and (b)(2). It is categorized as a dangerous drug pursuant to Business and Professions Code section 4022. It is a narcotic pain medication.

16. Tylenol #3, a brand name for 500 mg. acetaminophen with codeine 30 mg., is a Schedule III controlled substance as designated by Health and Safety Code section 11056(e)(2) and is categorized as a dangerous drug pursuant to Business and Professions Code section 4022. It is a narcotic pain medication.

17. Vicodin, trade name for a combination drug containing hydrocodone bitartrate (opioid analgesic) and acetaminophen, is a Schedule III controlled substance as defined in Health and Safety Code section 11056(e)(7) and is categorized as a dangerous drug according to Business and Professions Code section 4022. It is a narcotic pain medication.

FIRST CAUSE FOR DISCIPLINE

(False Hospital Records)

18. Respondent is subject to disciplinary action under section 2761, subdivisions (a) and (d), as defined in section 2762, subdivision (e), in that on or between July 10, 2002 and July 28, 2002, while on duty as a registered nurse at Antelope Valley Hospital, Respondent falsified, or made grossly inconsistent, unintelligible entries in hospital, patient, or other records, as follows:

a. **Patient No. 444345**

(1) On or about July 10, 2002, at 2104 hours, Respondent signed out[1] 2 Tylenol #3 tablets. At this time, there were no physician orders for Tylenol #3 for this patient. Respondent made no entry on the Medication Administration Record[2] (MAR) for the administration of Tylenol #3 to this patient. Respondent failed to account for the administration of 2 Tylenol #3 tablets in any hospital record

(2) On or about July 10, 2002, at 2106 hours (2 mins later), Respondent signed out 10mg Morphine Sulfate with witnessed wastage of 4mg. At this time, there were no physician orders for Morphine Sulfate for this patient. Respondent recorded on the MAR administration of 6mg Morphine Sulfate to this patient at 2100 hours. Respondent signed out and administered medication without physician authorization.

(3) On or about July 11, 2002, at 0632 hours, Respondent signed out 10mg Morphine Sulfate with witnessed wastage of 3mg for a total of 7mg Morphine Sulfate available for administration. Physician's orders were on July 11, 2002, for mild to moderate pain, 1 or 2 Tylenol #3 tablets every 4 hours, or, for severe pain, Morphine Sulfate 6mg every 3 - 4 hours as needed. Respondent recorded on the MAR a notation that the 0630 hours dosage was not given. Respondent signed out 7mg (10mg - 3mg) Morphine Sulfate instead of the authorized amount of 6mg Morphine Sulfate, and Respondent failed to account for the administration of 7mg Morphine Sulfate in any hospital record.

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1. All signed out medication is made using an automated unit dose medication dispensing system that records information such as patient name, physician orders, date and time medication was withdrawn, and the name of the licensed individual who withdrew and administered the medication.

2. Antelope Valley Hospital's Medication Administration Records (MAR) are created daily per patient. Each MAR covers two hospital shifts. The first shift begins and ends on the same day. The second shift swings through the end of one day into the beginning of another day. The first shift is 0730 to 1929 hours (7:30 am to 7:29 pm), and the second shift is 1930 to 0729 hours (7:30 pm to 7:29 am) the next day.

b. **Patient No. 849591**

(1) On or about July 11, 2002, at 1939 hours, Respondent signed out 10mg Morphine Sulfate with witnessed wastage of 5mg for this patient. Physician orders were on July 7, 2002, at 0130 hours, Morphine Sulfate (MS) 5mg IVP (intravenous push) every 2 hours PRN (as needed) for pain. On the MAR, the last documented administration of 5mg Morphine Sulfate was July 8, 2002, at 2100 hours. Respondent made no entry on the MAR for administration of Morphine Sulfate to this patient. Respondent failed to account for the administration of 5mg Morphine Sulfate in any hospital record.

(2) On or about July 11, 2002, at 1946 hours (7 mins later), Respondent signed out 1 Darvocet N100 tablet for this patient. Physician's orders were on July 8, 2002, at 2258 hours, Darvocet N100 one tablet QID (4 times per day or every 6 hours). Respondent made no entry on the MAR for the administration of Darvocet to this patient. Respondent failed to account for the administration of 1 Darvocet N100 tablet in any hospital record.

c. **Patient No. 578164**

On or about July 11, 2002, at 2301 hours, Respondent signed out 10mg Morphine Sulfate with witnessed wastage of 2mg for this patient (8mg MS available). Physician's orders were on July 7, 2002, Morphine Sulfate 8mg IVP every 2 hours as needed for pain. Respondent made no entry on the MAR for the administration of Morphine Sulfate to this patient. Respondent failed to account for the administration of 8mg Morphine Sulfate in any hospital record.

d. **Patient No. 849722**

On or about July 12, 2002, at 0138 hours, Respondent signed out 2 quantities of 4mg Morphine Sulfate (8mg MS available). Physician's orders were on July 9, 2002, at 0251 hours, Morphine Sulfate 4-6mg every 2-4 hours if pain. Respondent recorded on the MAR administration of 6mg Morphine Sulfate for this patient at 0140 hours, leaving 2mg Morphine Sulfate not administered. Respondent signed out 2mg Morphine Sulfate without authorization, and Respondent failed to account for the administration of 2mg Morphine Sulfate in any hospital record.

e. **Patient No. 468358**

On or about July 18, 2002, at 0059 hours, Respondent signed out 4mg Morphine Sulfate for this patient. Physician orders were on July 17, 2002, at 0431 hours, Morphine Sulfate 2-4mg IV every 3 hours as needed for increased pain (hold if systolic blood pressure is less than 100 or respiration rate is less than 10). The Medication Administration Record, July 17, 2002, second shift column records, "Hold" for administration of Morphine Sulfate. Respondent made no entry on the MAR for the administration of Morphine Sulfate to this patient. Respondent failed to account for administration of 4mg Morphine Sulfate in any hospital record.

f. **Patient No. 850421**

On or about July 18, 2002, at 2104 hours, Respondent signed out 2mg Dilaudid. Physician's orders were on July 17, 2002, at 1450 hours, Dilaudid 1-2 mg IV every 2 hours as needed. Respondent made no entry on the MAR for the administration of Dilaudid for this patient. Respondent failed to account for the administration of 2mg Dilaudid in any hospital record.

g. **Patient No. 588977**

(1) On or about July 18, 2002, at 2349 hours, Respondent signed out 2mg Dilaudid. Physician's orders were on July 17, 2002, at 2130 hours, Dilaudid 2mg IVP every 2 hours as needed for pain. Respondent made no entry on the MAR for the administration of Dilaudid to this patient. Respondent failed to account for the administration of 2mg Dilaudid in any hospital record.

(2) On or about July 18, 2002, at 2350 hours (1 min later), Respondent signed out 1 Vicodin tablet for this patient. Physician's orders were on July 18, 2002, at 0010 hours, Vicodin 1 tablet 4 times a day as needed. Approximately 1 hour after signing out, on July 19, 2002, at 0100 hours, Respondent recorded on the MAR administration of 1 Vicodin tablet to this patient. Respondent failed to immediately administer medication to this patient in accordance with functions and duties of a registered nurse.

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h. **Patient No. 803801**

(1) On or about July 23, 2002, at 2047 hours, Respondent signed out 2mg Dilaudid with witnessed wastage of 1mg Dilaudid for this patient (1mg Dilaudid available). Physician's orders were on July 23, 2002, at 1745 hours, Dilaudid 1mg IVP every 4 hours as needed. Respondent recorded on the MAR for July 23, 2002, at 2100 hours, that 1mg Dilaudid was refused by the patient. Respondent failed to account for the administration of 1mg Dilaudid in any hospital record.

(2) On or about July 24, 2002, at 2047 hours, Respondent signed out 2mg Dilaudid with witnessed wastage of 1mg Dilaudid for this patient (1mg Dilaudid available). Physician's orders were on July 23, 2002, at 1745 hours, Dilaudid 1mg IVP every 4 hours as needed. Respondent made no entry on the MAR for the administration of Dilaudid to this patient. Respondent failed to account for the administration of 1mg Dilaudid in any hospital record.

(3) On or about July 25, 2002, at 0220 hours, Respondent signed out 2mg Dilaudid for this patient. Physician's orders were on July 23, 2002, at 1745 hours, Dilaudid 1mg IVP every 4 hours as needed. Respondent made no entry on the MAR for the administration of Dilaudid to this patient. Respondent failed to account for the administration of 2mg Dilaudid in any hospital record.

i. **Patient No. 701406**

On or about July 23, 2002, at 2257 hours, Respondent signed out 100mg Demerol for this patient. Physician orders were on July 21, 2002, at 2150 hours, Demerol 50mg IV every 3 hours, hold if patient is lethargic. But, the nurses notes state that on or about July 23, 2002, at 1600 hours, patient No. 701406 was "taken to surgery," and, on or about July 24, 2002, at 0215 hours, patient No. 701406 was "received from recovery . . . Pt sedated from anesthesia." This patient was in Surgery/Recovery at the time of this withdrawal and not under the care of Respondent. Respondent made no entry on the MAR for the administration of Demerol to this patient. Respondent failed to account for the administration of 100mg Demerol in any hospital record.

j. **Patient No. 850097**

On or about July 24, 2002, at 2119 hours, Respondent signed out 75mg Demerol. Physician's orders were on July 23, 2002, at 2005 hours, 50mg-75mg IVP every 3 to 4 hours as needed. The MAR records entries, by other hospital nursing staff, for the administration of 50mg Demerol at 2000 hours and 50mg Demerol at 0300 hours to this patient. Respondent made no entry on the MAR for the administration of Demerol to this patient. Respondent signed out 75mg Demerol without physician authorization, and Respondent failed to account for the administration of 75mg Demerol in any hospital record.

k. **Patient No. 730402**

(1) On or about July 27, 2002, at 2009 hours, Respondent signed out 10mg Morphine Sulfate for this patient. At this time, there were no physician orders for Morphine Sulfate for this patient. Respondent made no entry on the MAR for the administration of Morphine Sulfate to this patient. Respondent signed out 10mg Morphine Sulfate without physician authorization, and Respondent failed to account for administration of 10mg Morphine Sulfate in any hospital record.

(2) On or about July 27, 2002, at 2119 hours, Respondent signed out 4mg Morphine Sulfate with witnessed wastage of 2mg for this patient (2mg Morphine Sulfate available). Physician's orders were on July 27, 2002, at 2130 hours (11 mins later), Morphine Sulfate 2mg IVP every 6 hours as needed. Respondent recorded on the MAR administration of 2mg Morphine Sulfate to this patient on July 27, 2002, at 2130 hours. Respondent signed out Morphine Sulfate for this patient before she received physician authorization.

l. **Patient No. 652138**

(1) On or about July 28, 2002, at 0519 hours, Respondent signed out 2mg Dilaudid (Hydromorphone HCL) with witnessed wastage of 1.5mg (0.5mg Dilaudid available). Physician's orders on July 11, 2002, at 1535 hours, were Dilaudid 0.5mg IV every 4 hours as needed for pain. Respondent made no entry on the MAR for the administration of Dilaudid to this patient. Respondent failed to account for the administration of 0.5mg Dilaudid (Hydromorphone HCL) in any hospital record.

(2) On or about July 28, 2002, at 2313 hours, Respondent signed out 2mg Dilaudid with witnessed wastage of 1.5mg (0.5mg Dilaudid available). Physician's orders on July 11, 2002, at 1535 hours, were Dilaudid 0.5mg IV every 4 hours as needed for pain. Respondent recorded on the MAR on July 28, 2002, at 2300 hours, 0.5mg Dilaudid (Hydromorphone HCL) not administered, "pt refused." Respondent failed to account for the administration of 0.5mg Dilaudid (Hydromorphone HCL) in any hospital record.

SECOND CAUSE FOR DISCIPLINE

(Obtaining or Possessing Controlled Substances / Dangerous Drugs)

19. Respondent is subject to disciplinary action under section 2761, subdivision (a), in conjunction with sections 2762, subdivision (a), and 4060, and Health and Safety Code section 11377, subdivision (a), in that on or between July 10, 2002 and July 28, 2002, while on duty as a registered nurse at Antelope Valley Hospital, Respondent obtained or possessed controlled substances and dangerous drugs, as set forth above in paragraph 18, more specifically, as follows:

Date	Time	Controlled Substance	Patient No.
7/10/02	2104	2 Tylenol #3	444345
7/11/02	0632	7mg Morphine Sulfate	444345
7/11/02	1939	5mg Morphine Sulfate	849591
7/11/02	1946	1 Darvocet N-100	849591
7/11/02	2301	8mg Morphine Sulfate	578164
7/12/02	0138	2mg Morphine Sulfate	849722
7/18/02	0059	4mg Morphine Sulfate	468358
7/18/02	2104	2mg Dilaudid	850421
7/18/02	2349	2mg Dilaudid	588977
7/23/02	2047	1mg Dilaudid	803801
7/23/02	2257	100mg Demerol	701406
7/24/02	2047	1mg Dilaudid	803801
7/24/02	2119	75mg Demerol	850097

7/25/02	0220	2mg Dilaudid	803801
7/27/02	2009	10mg Morphine Sulfate	730402
7/28/02	0519	0.5mg Dilaudid	652138
7/28/02	2313	0.5mg Dilaudid	652138

THIRD CAUSE FOR DISCIPLINE

(Unprofessional Conduct - Dishonest Acts)

20. Respondent is subject to disciplinary action under section 2761, subdivision (a), in conjunction with California Code of Regulations, title 16, section 1444, on the grounds of unprofessional conduct, in that while employed as a registered nurse, Respondent committed unprofessional dishonest acts which directly relate to the qualifications, functions, and duties of a registered nurse, when she a) failed to account for the administration of controlled substances in accordance with hospital policy and procedure, b) failed to immediately administer medication to patients in accordance with the functions and duties of a registered nurse, c) failed to properly record the disposition of dangerous drugs/controlled substances in any hospital record, d) obtained controlled substances without physician authorization, e) obtained controlled substances without valid prescriptions, and f) possessed controlled substances without valid prescriptions, as set forth above in paragraphs 18 and 19.

PRAYER

WHEREFORE, Complainant requests that a hearing be held on the matters herein alleged, and that following the hearing, the Board of Registered Nursing issue a decision:

1. Revoking or suspending Registered Nurse License No. 581531, issued to Kelly Theresa Johnson.

2. Ordering Kelly Theresa Johnson to pay the Board of Registered Nursing the reasonable costs of the investigation and enforcement of this case, pursuant to Business and Professions Code section 125.3;

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3. Taking such other and further action as deemed necessary and proper.

DATED: 10/25/05

RUTH ANN TERRY, M.P.H., R.N.
Executive Officer
Board of Registered Nursing
Department of Consumer Affairs
State of California

Complainant

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